

# Patient Education in Primary Care

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Welcome to our resource for patient education and primary care!<sup>1</sup>

### WHAT IS IT?

This newsletter provides a mechanism to help meet the challenges of incorporating effective patient education into primary care.

### WHO IS IT FOR?

VA Primary Care Teams, Patient Health Education Coordinators and Patient Health Education Committee members, VISN and VAMC decision makers.

## MOVE! Program for Weight Management

When the *MOVE!* program is fully implemented in VHA facilities, it will be the largest and most comprehensive weight management and physical activity program associated with a medical care system in the United States. *MOVE!* (Managing Overweight/Obesity for Veterans Everywhere), developed by the VA National Center for Health Promotion and Disease Prevention, is currently undergoing feasibility trials in seventeen VA facilities. "When it's implemented, virtually all overweight patients will get some kind of intervention," says Richard Harvey, Assistant Director for Preventive Behavior at the Center and lead developer for the *MOVE!* program.

The program provides a standardized format for weight management and physical activity evaluation and treatment in VHA and should require only minor adjustments in allocation of resources. The treatment components are deliverable in modules, and tailored for individual differences in medical status, age, and readiness to engage in weight management and physical activity behaviors. Program elements are consistent with current evidence-based

# MOVE!

standards for weight management and physical activity. An executive council of nationally recognized leaders in weight management and physical activity provides oversight to the program, and a VA Steering committee will provide leadership in its national implementation. All procedures for patient encounters are detailed in a manual for clinicians, including suggested scripts for these encounters. *MOVE!* is intended to be a lifetime program, not a single or time-limited intervention.

A progressive treatment model is utilized, as clinically indicated. The steps increase in intensity and/or invasiveness. Systematic progression through each level is not necessary. Progression is determined by a patient's preference, weight history, medical condition, and psychological factors. The levels include:

- **Level One**—Initial clinical and computerized assessment, tailored self-help written materials, and scheduled follow-up contact as indicated;
- **Level Two**—Components as described in Level One, plus referral to specialized areas as needed, and/or on-site weekly multi-disciplinary group clinics/classes, and scheduled follow-up contact as indicated;
- **Level Three**—Addition of weight control pharmacological agents to either of the above levels;
- **Level Four**—Brief admission to an inpatient or residential weight control program in a VA medical center offering such treatment, and scheduled follow-up contact as indicated;
- **Level Five**—Consideration for bariatric surgery, and scheduled follow-up contact as indicated.

## Level One Treatment

At least annually during a primary care or other medical care visit, each patient will be assessed for Body Mass Index (BMI), and optional measurement of waist circumference. A BMI of 25 or more is considered overweight, and a BMI of 30 or greater is obese. A waist circumference of 40 inches or more for males, and 35 inches or more for females, is considered at risk for obesity-related disease. Patients identified during the initial clinical encounter as overweight, obese, or at risk are advised to lose weight and offered an opportunity to participate in the *MOVE!* program. The various program tracks and options are described during this visit. Individuals who are unwilling or unable to enroll at that time are counseled in accordance with the patient's stage of readiness to change, with the goal of advancing his/her readiness to change. A handout addressing "pre-contemplation" issues is offered to such patients.

Patients who agree to enroll in the *MOVE!* program are asked to complete a computerized initial assessment questionnaire. The completed questionnaire is then scored by computer, and two reports are generated:

- the patient receives an individually tailored report including instructions and recommendations for beginning the *MOVE!* program;
- the clinician receives a description of relevant patient factors, specific instructions and recommendations for assisting the patient, and a list of individually tailored information and instructional handouts to be given to the patient. This report may then become a progress note in the CPRS medical record. Specific "alarm flags" are generated by certain responses to the questions, resulting in a recommendation for referral of the patient to the indicated specialist for further evaluation or treatment of conditions that might influence weight management treatment (e.g. certain medical conditions, psychological disturbances, etc.) All patient materials are prepared at a reading and comprehension level commensurate with that of the general veteran population. Patients for whom walking is recommended may also be given a pedometer.

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The clinician and patient then formulate a patient-centered plan for carrying out the program. Telephone follow-up contact is recommended at frequent intervals:

- 1 week after initial contact
- 3 weeks after initial contact
- every 2-4 weeks thereafter until goals are achieved
- every 3-6 months as needed for maintenance
- these intervals may be altered as clinically indicated.

## Level Two Treatment

Patients may require brief individual attention in the areas of nutrition, physical activity, psychosocial issues, or medical evaluation and treatment. Referral for any of these services is a Level Two intervention. Intensive on-site group classes also constitute Level Two intervention. Patients may move into Level Two because they:

- failed to lose weight with less intensive interventions
- need closer support and supervision, or
- are motivated to attend weekly group sessions at the outset, or at any point during treatment.

The small group classes meet weekly so patients can learn about and discuss additional strategies for weight control. Each session lasts 60-120 minutes and features topical discussions; one on nutritional information, and another on a behavioral or physical activity topic. A progress review is also carried out for each patient in the group, and each patient is weighed. There is no recommended duration of such treatment. Each session is scripted and educational materials/handouts for the session are available on a wide variety of topics.

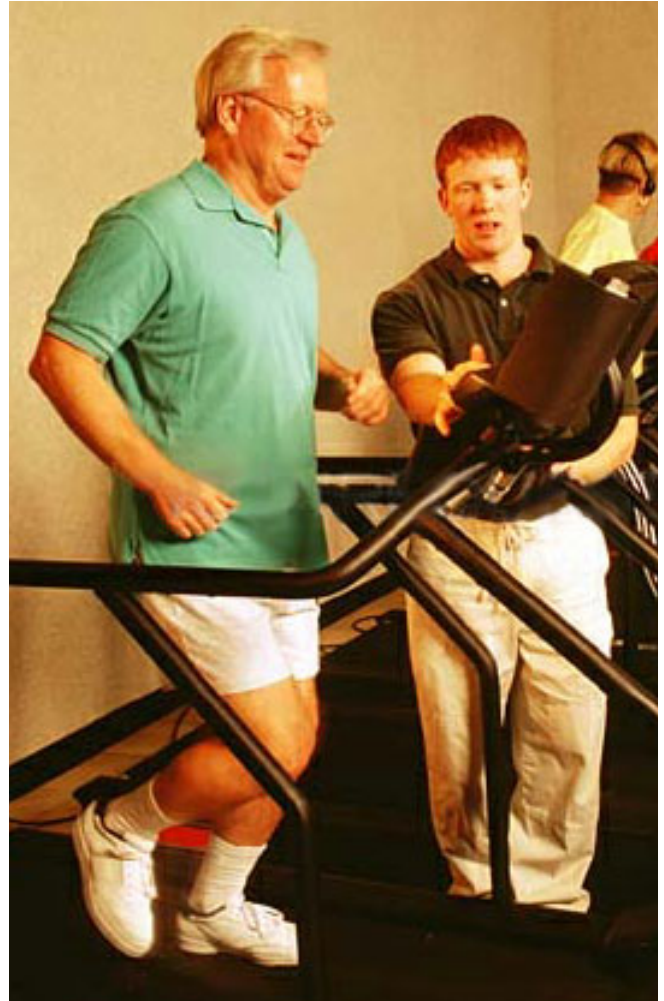
## Level Three Treatment

The addition of pharmacological weight control agents to the treatment plan constitutes treatment at Level Three. This treatment may be concurrent with Level One or Level Two treatment. Patients who may benefit from pharmacological augmentation of treatment may be selected on the basis of:

- failure to successfully lose weight with less intensive treatment, or
- history of repeated failure to maintain weight loss, or
- poor impulse control, and
- BMI of 27 or more with the presence of at least two major risk factors, or a BMI of 30 or more with or without risk factors.

## Level Four Treatment

Inpatient or residential treatment may be utilized, when available, as a Level Four treatment. Candidates for inpatient or residential treatment of obesity may be selected on the basis of:



- failure to achieve significant weight loss with less intensive treatment,
- BMI of 40 or greater, or
- inability to participate in less intensive treatment due to transportation or other constraints.

Inpatient or residential care may vary in duration as clinically necessary. In addition to careful assessment, essential components of inpatient care include:

- limited access to food, with supervised low calorie meals and food portions
- intensive nutritional education
- food planning and preparation classes
- an exercise prescription, with supervised physical activity
- intensive physical activity education
- intensive behavior modification, and education on behavioral strategies
- group therapy, focusing upon cognitive and emotional reeducation
- pharmacotherapy, if indicated
- carefully planned follow up.

## Level Five Treatment

Bariatric gastric bypass surgery (GBS) or other bariatric surgical procedures constitute the Level Five treatment of last resort. Patients may be referred for a bariatric surgical procedure to VA medical centers where this service is available. Selection criteria for this treatment option must be derived based on latest evidence, including:

- failure to achieve significant weight loss in levels one through four,
- BMI of 40 or greater, or BMI of 35 or greater with co-morbid conditions,
- formal psychological evaluation showing patient is emotionally stable, able to control impulses, and able to maintain the frequent and long term follow-up contact necessary for successful outcome from these procedures,
- ability to attend structured GBS group therapy, both pre-surgically and following surgery, proctored by a multidisciplinary team including nutritional, behavioral, physical activity, medical and GBS surgical representatives.

“It’s a busy time for us,” said Harvey. “We’re finalizing materials and procedures based on the results of the feasibility studies, and we’re working on integrating *MOVE!* program documentation within CPRS. We are also working to integrate our efforts with the My HealtheVet website. We hope to roll out the program to the entire VHA health care system by July 2005, but we anticipate that VISNs 2 and 8 may start implementation sooner than that,” he added.

Virginia Zele, MS, RD, Weight Management Coordinator at the Center, participated in the development of the program, and Kenneth Jones, PhD, serves as program manager for *MOVE!*.

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## Patient Education/Primary Care Program Notes

### COLLAGE: Communication Tools for VHA

“COLLAGE has lots of potential to support VHA staff,” says Frances Matt, Project Director. “We’re very excited about the resources we can offer VHA. We think COLLAGE’s tools can help VHA manage and disseminate knowledge throughout the system and encourage collaboration among staff to improve patient care.”

COLLAGE is a knowledge management product of the Veteran’s Evidenced-based Research Dissemination Implementation Center (VERDICT) located at the San Antonio Division of the South Texas VA Healthcare System. “COLLAGE has demonstrated its capability to provide a composite of web-based, interactive, people-centered knowledge management tools and personal support service across a diverse range of VHA communities of practice,” Matt added.

During 2003-2004, COLLAGE greatly expanded the number and diversity of participating VA communities of practice from 4 to 14, including researchers, patient educators, diabetes educators, VA health economists and advanced clinic access. COLLAGE now offers more technically sophisticated functions for communities, e.g. “locked” access to parts of a homepage, storage of audio recordings, supportive multi-site research capacity, and survey development tools. In addition, COLLAGE developed a database of VHA medical professionals containing 80,000 names. This database was initially piloted by COLLAGE to announce VA’s license to the online New England Journal of Medicine with a link placed on the COLLAGE homepage. Over 46,000 email announcements were sent; as a result of this marketing effort, COLLAGE experienced a tripling of its previous monthly number of unique visitors. COLLAGE has also served as host to two nationwide surveys: the pilot for the VANOD Nurse Executive Survey, and the VHA Senior Executive Survey on Nursing Commission.



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The design for COLLAGE's knowledge management tools and services was guided by the dimensions of Communities of Practice:

- **Knowledge Sharing:** the character of the knowledge that the members want to share
  - COLLAGE features allow members to share both explicit knowledge (that which can be communicated in writing, such as in documents) and tacit knowledge (that which is born from subjective experience and shared through dialogue, such as in mutual problem solving)
- **Community Identity:** the members' sense of community identity
  - Each COLLAGE Community of Practice receives its own homepage tailored in both appearance and function in accordance with the identified needs of the community membership. Community identity is further supported with the use of logos, members' photographs and biographies allowing other members to begin to place a face and history with a name, and to recognize their community's wealth of expertise. This results in a homepage where the community space reflects the "feel" of the community and its common identity.
- **Knowledge integration:** the degree to which knowledge content is integrated into the member's everyday work
  - COLLAGE assists communities to integrate the results of their efforts into their everyday work by providing individualized, valued, people-centric support. This hands-on approach enables knowledge sharing to become a natural process for the individuals, not an added burden. For example, COLLAGE capitalizes on existing communication practices prevalent in each community and begins building from there.

For VHA patient educators, COLLAGE has been useful in a variety of ways:

- Over 130 documents relating to patient education—instructional materials for patients and staff that were created at VHA facilities, position descriptions, presentations and handouts—have been uploaded to COLLAGE where they are now available to VHA staff; clinicians interested in particular materials can now check to see whether such items have already been created, which saves time and effort
- COLLAGE archives several patient education newsletters for easy access to current and back issues
- Patient educators can post queries to the field for assistance with problem solving, to learn about the experiences and opinions of members of the group on a particular topic, or to brainstorm ideas for creating products and services to address VHA initiatives
- COLLAGE also archives patient educator email dialogues by topic over the previous four years so anyone can query whether and how a topic has been addressed
- Upcoming events of interest to patient educators are posted on the community's calendar
- COLLAGE archives audio recordings and support materials from monthly and quarterly patient education conference calls for staff who were unable to attend them or who want to review them or to share them with colleagues
- The patient educators' homepage on COLLAGE features the monthly national health observances; users can link to VA and non-VA sites for additional information on any of the topics.

When an individual registers for the patient educator community, s/he is automatically notified of new items added to the group's resources. The patient educators community is open to any VHA staff who want to use its resources, although some communities of practice restrict all or parts of their homepages to individuals authorized to enroll in the group.

COLLAGE's web-based tools and services are tailored to the unique knowledge management needs of its VHA client-communities. It is housed on the VA intranet, affording it all the protection and benefits derived from being behind the firewall while being fully accessible to all VHA employees with VA intranet access. The web address for COLLAGE is: <http://vaww.collage.research.med.va.gov>. Table 1. summarizes COLLAGE's current features and functions that are available to client-communities, and Table 2 lists the services offered by COLLAGE.

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**Table 1. COLLAGE Features and Functions**

| FEATURE                     | FUNCTION  |
|-----------------------------|---|
| Community File Upload       | Allows sharing of personal documents and drafts; individuals can access, download, revise, and re-load documents, e.g. spread sheets, slide presentations, tables, articles, minutes, and reports   |
| Resource Library            | Supports storage, search, and retrieval of formally published documents with wide audience appeal, such as a journal article, submitted to and catalogued by the medical cyber-librarian  |
| Discussion Board            | For synchronous and asynchronous communication, e.g. asking questions, sharing insights, problem solving, brain storming; ideal for situations where a large volume of responses is anticipated or across time zones; permits tracking of conversations according to topic or number of responses |
| E-mail ListServe Archive    | Captures, categorizes and stores email "chatter" not entered on the discussion board but holding value as a categorized, searchable history of the community dialogue   |
| VA Website Listing          | Provides a searchable database of VA website links  |
| Community Calendar          | Enables community to be alerted to upcoming events  |
| Audio-Recording Archive     | Allows for recording and archiving of audio presentations, with/without accompanying PowerPoint presentations, handouts, and reference documents; allows for the storage and retrieval of community teleconference calls  |
| Build-A-Survey              | Provides a survey template allowing communities to design and administer on-line community-specific surveys   |
| Multi-site Research Support | Links multiple VAMC study sites, supporting the role of site research coordinators  |
| Restricted Access           | Provides for restricted access to whole/part of a community's homepage through use of login   |
| Community Registration      | Builds profile of community members: email address, phone, photograph, professional credentials and bio for others to access  |

**Table 2. COLLAGE Services**

| COLLAGE SERVICES                 |   |
|----------------------------------|---|
| On-line Training                 | Provision of group or one-on-one hands-on training, via telephone & computer, on use of COLLAGE's interactive tools                     |
| Tailored Homepage Design         | Individualized homepage functionality and appearance designed to meet community needs as indicated by response to community assessment. |
| Help Hot Line                    | Live assistance available during normal business hours.   |
| Visitors Record                  | Tracks number of site visitors; can also generate statistics on usage patterns.   |
| Direct E-mail Marketing Database | A marketing database of e-mail addresses for all VHA health care professionals  |

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|   |  |  |
|---|--|--|
| <b>COLLAGE • PATIENT EDUCATORS</b> <i>Homepage</i>  |  |  |
| <a href="#">HOME</a>   <a href="#">Member directory</a>   <a href="#">ABOUT</a>   <a href="#">HELP</a>   Welcome Frances Matt (member)   Wednesday, 17 March 2004   |  |  |
| <b>Resources</b><br><br>Patient Ed Holdings<br>in<br><a href="#">COLLAGE Library</a><br><br><a href="#">Community Files</a><br>(with upload feature)<br><br><br>- select -<br><a href="#">ListServe Archive</a> | <b>Topics</b><br><br><p style="text-align: center;"><b>New Feature - <a href="#">Audio Files Page</a></b></p> <p style="text-align: center;">See a list of available taped conference calls by clicking on the above or under Tools at right</p> <hr/> <p><b>National Health Observances</b> for the month of <a href="#">March</a> from the <b>National Health Information Center</b>.</p><br><p><b>Tuberculosis support documents</b> from the VA National Center for Health Promotion and Disease Prevention</p><br><p style="text-align: center;"><a href="#">HealthPOWER! Prevention News</a>, March 2004</p> | <b>Tools</b><br><br><div style="background-color: red; color: white; text-align: center; padding: 5px;"><b>Feedback</b></div><br><p style="text-align: center;"><a href="#">Audio Files Page</a></p> <hr/> <br><a href="#">Calendar</a><br><hr/> <br><a href="#">File Upload</a> |

Originally funded four years ago as an HSR&D research project, COLLAGE was conceptualized as an on-line vehicle supporting efforts to facilitate diffusion of research evidence and clinical practice innovation across VHA's geographically dispersed health care system. To support dissemination of knowledge, the COLLAGE project was designed to:

- house easily accessible sources of research evidence on topics such as clinical practice guidelines (CPGs) and concordant professional and healthcare related documents, and
- provide web space tools that would afford opportunity to exchange innovative implementation practices, stories of local experience, and summaries of lessons learned as well as participatory problem-solving dialogues.

Expanded use of COLLAGE tools offers VHA:

- greater on-line collaboration between geographically-dispersed VHA facilities to replicate existing successful change management implementations, such as Advanced Clinic Access
- greater employee exposure on how evidenced-based research is pulled into daily clinical practice
- less costly means of disseminating professional information across the widest organizational audience, other than via large, expensive, face-to-face professional conferences
- greater sharing of what has already been shown to work in everyday practice, or has already been created, rather than continuing to "reinvent the wheel"
- more sophisticated, flexible, people-centric communication tools that support the continuing evolution of VHA communication culture beyond that of the prevailing teleconference call and group e-mail list functions
- smoother implementation of an enterprise-wide communications plan that helps employees align VHA vision, strategic goals, and individual action.

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## Patient Education Resources

### Advanced Access Videos

To help patients learn how to use the new advanced access appointment scheduling system, staff at the Washington, DC VAMC developed two videos designed to be shown in the primary care waiting areas. The videos, *Waiting Room Blues*, and *Gone Fishing*, depict the benefits of the new system; each runs approximately 5 minutes.

Copies of the videos are being distributed to all VHA facilities, along with a third video developed in VISN 18 as a training tool for scheduling clerks. The video, *VistA Scheduling: Making a Difference*, runs approximately 20 minutes.

At medical centers, materials will be sent to the patient education contact person and to the library. At VISNs, materials will be sent to the designated points of contact for advanced clinic access.

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## When Your Patients Are in Mourning

(Editor's Note: The following article, written by Jennifer Kreger, MD, was reproduced, with permission, from the November-December, 2003 issue of *Family Practice Management*. Copyright ©2003 American Academy of Family Physicians. All rights reserved.)

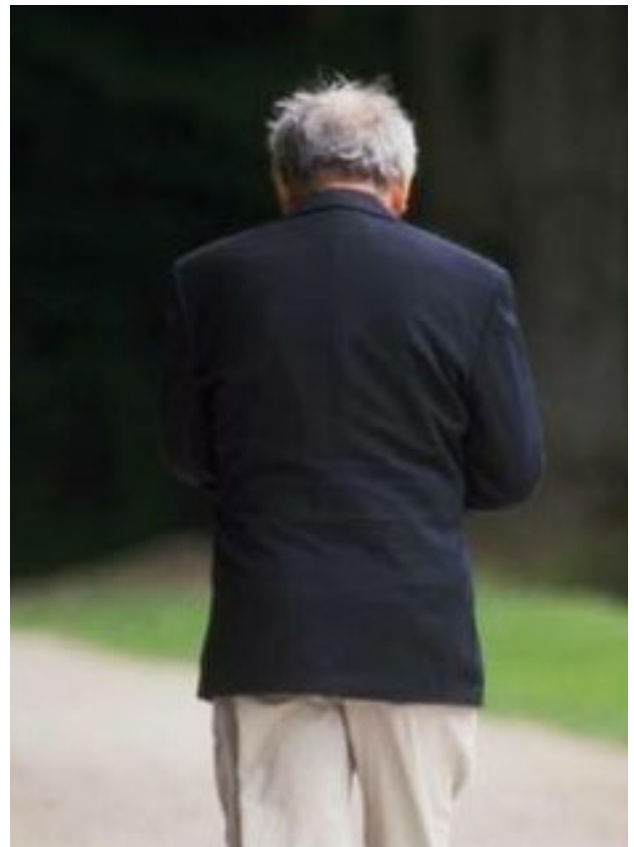
I practice family medicine in a small and geographically isolated community in northern California in which people have learned to look out for one another. Though I've only been here for seven years, my office staff have known many of my patients for three decades or more. Every Thursday, when the local paper comes out, Barbara (my office manager) looks through the obituary section and affixes sticky notes to items of interest, saying, "That's your patient's mother" or "This is Mrs. So-and-so's spouse." Then, I know it's time to make a condolence call and put a copy of my Mourners' Rights handout in the mail. I write a one- to two-line personal message at the top and sign my name at the bottom. Sometimes I discover during a visit that my patient is a mourner. Then I immediately reach for the handout and we go over it together.

I share the Mourners' Rights handout with my patients for three important reasons: it saves time, it prevents health crises and it reminds my patients that I am committed to them.

It saves time because knowing that I've put my thoughts on paper allows me to focus on listening to the patient. Before I wrote the handout, I found myself trying to express its main ideas using more words than necessary. It saves time the way all handouts do: by allowing the patient to read it over and over without the doctor having to speak the words over and over. With those patients who tend to be reticent, it saves time by eliminating the portion of a phone call or visit during which the patient wonders aloud whether it's appropriate to be "bothering you"; it clarifies that all symptoms of mourning are legitimate topics for discussion. With those patients who tend to obsess over each new symptom, it saves time by providing reassurance and backing up your advice should you later diagnose a symptom as a benign manifestation of grief.

The handout prevents health crises by giving patients a critically important but often unpublicized piece of information: As mourners, they are at high risk of having health problems right now, and their doctor and other health care professionals can make a real difference by intensifying care in this period. Until I wrote the handout, I had noticed that most of my hypertensive, diabetic and hyperlipidemic patients would give up their exercise programs for prolonged periods during mourning, and patients of all kinds would lose track of medication refills and other aspects of self-care. These mourning patients needed extra reminders and attention to ensure their own health care needs were not being neglected.

The handout is one of the most direct ways I know to tell my mourning patients I am here for them, not because they are "holding it together," not because they are "falling apart," but because they are human. The opportunity to be a permanent ally to a human being, regardless of age, gender, diagnosis or prognosis is one of the great privileges of being a family physician. When we validate our patients' experiences and welcome their hearts in this way, they are deeply, openly and repeatedly appreciative.



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## Mourner's Rights

When your parent, child, sibling or partner dies, you become a mourner. You stay a mourner for at least a year.

While you are a mourner, you are at a higher-than-usual risk for:

- dying,
- getting a new illness,
- getting a flare-up of an illness you already have,
- not getting enough sleep (or sleeping too much),
- becoming malnourished,
- making decisions that you later regret,
- thinking that you are losing your mind.

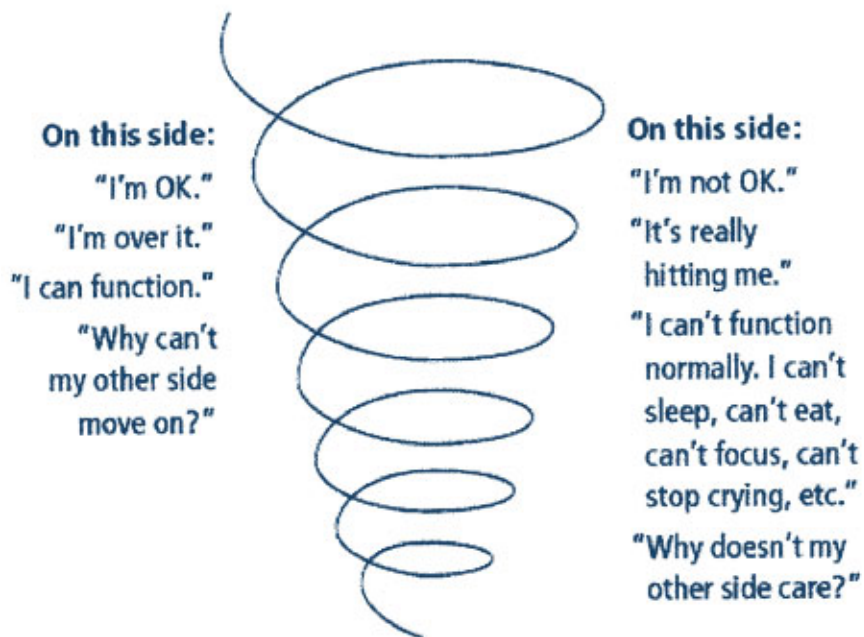
On the positive side, you are also more likely than usual to:

- notice what you appreciate about being alive,
- become more aware of your deepest values and top priorities,
- get a clear view of the status of all your relationships.

You deserve lots of extra support while you are a mourner. You deserve help to protect your physical and mental health, and you deserve support to take advantage of what is special and precious about mourning. This is true whether the person who died was young or old, whether the two of you were close or estranged, whether the person died slowly or suddenly, and whether you expected the person's death to "get to you."

In some cultures, a mourner is considered legally insane for a year. The mourner is allowed to blaspheme, break promises, wake people up at night, change his or her mind repeatedly, and express emotions, including anger at the one who has died. While our culture may not provide as much grace to mourners, you should give yourself a break.

Many mourners find that grief takes the shape of a spiral. You spin from feeling normal to grief-stricken, and back again.



The swings get less dramatic as time goes by, but they don't stop happening entirely.

If you would like to talk about your grief, or any other issues, please feel free to give me a call.

# Teach Tip



## Helping Patients Who Have Relapsed

Patients at this stage have experienced a minor slip or a major relapse backward into old behaviors. Often, they feel discouraged and demoralized. Patients may revert all the way to pre-contemplation (not willing to even consider trying again), or to some intermediate stage.

The clinician's role at this stage is to support the patient in an effort to help him renew his determination, resume action, and maintain his efforts toward change.

Try any of the following strategies, tailoring your approach to the needs of the particular patient:

- Establish a positive partnering relationship with the patient (“I’m sorry you had a setback, but I think it’s great that you’re trying to make this change, and I’d like to help you with it.”)
- Provide support (“You don’t throw away the whole set of china if you break one dish, do you?”)
- Help the patient differentiate between a slip and relapse
- Remind the patient that it often takes multiple attempts to achieve the goal (“This doesn’t mean you’re a failure. It means you had a slip/relapse.”)
- Help the patient talk about his feelings about the slip/relapse (“At what point did it become difficult for you?” “What actions did you take when you realized you had relapsed?” “Where do we go from here?”)
- Teach/re-teach necessary skills
- Help the patient re-establish goals and a plan of action (“Let’s revisit your goals and strategies.” “What was working for you?” “What wasn’t working?”)
- Refer to a self-help or support group if the patient is interested (“Sometimes it helps to talk with others who are working on the same behavior.”)
- Teach mental rehearsal skills to help the patient anticipate challenges and handle them without relapsing (“How will you handle it when \_\_\_\_\_?”)



## How do we know patient education works?

### Cross-sectional vs. Longitudinal Performance Assessments in Diabetes Management

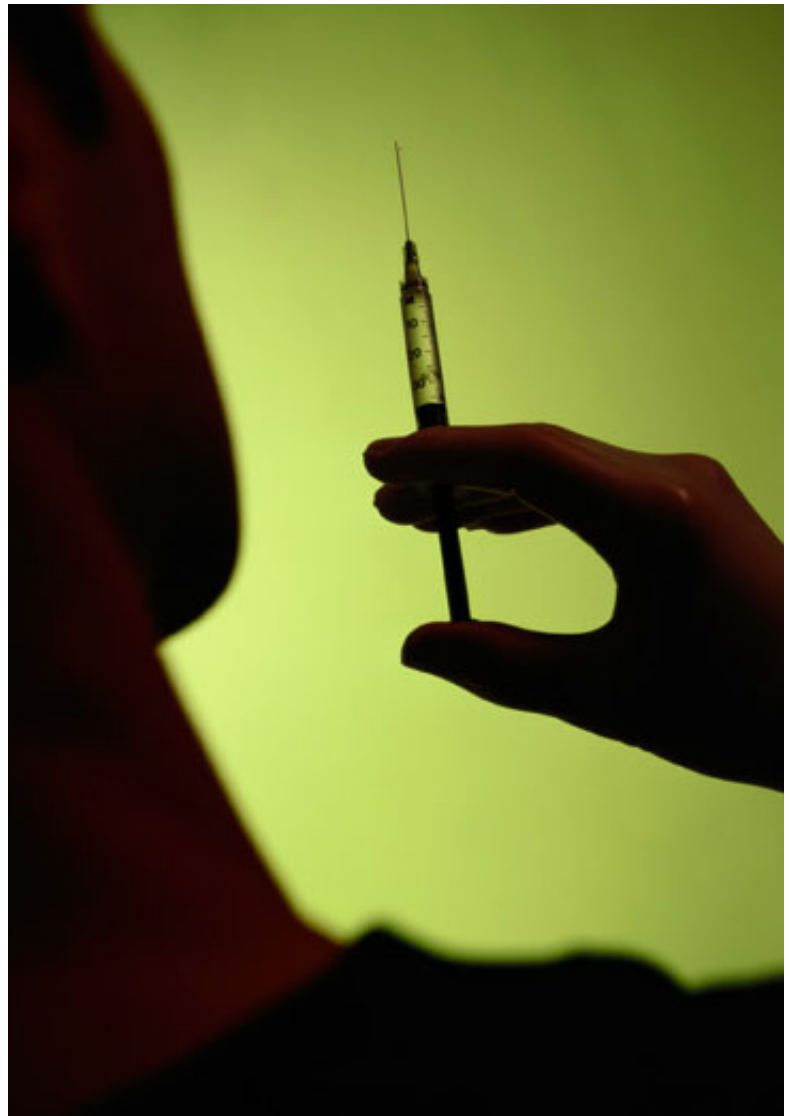
This study, conducted by researchers at the Center for Health Equity and Research and Promotion at the Philadelphia VA Medical Center, investigated whether there were differences in performance assessment of patient management of diabetes depending on the method used to analyze the patients' performance.

The investigators compared HBA1c levels among diabetic patients in an integrated delivery system who had primary care visits and HBA1c testing in both 1999 and 2000, using both cross-sectional and longitudinal measurements of performance.

In the cross-sectional analysis, they found a small increase in the proportion of patients who achieved an HBA1c level of <8.0% (from 73.1% in 1999 to 75.6% in 2000). But using longitudinal analysis of the performance of the same patients, they found that patients aged 35 to 49 were 2.5 times as likely to switch from good to poor control, and only 0.6 times as likely to switch from poor to good control as patients 64 years old or older. When compared with white patients, black patients were 1.76 times as likely to switch from good to poor control and only 0.5 times as likely to switch from poor to good control.

The authors argue that since patient care is longitudinal, cross-sectional assessments are poorer indicators of care than longitudinal measurements. They contend that cross-sectional performance assessments can mask changes in diabetes control, especially if they do not account for patient sociodemographic factors that may influence diabetes management.

*Weiner M, Long J. (2004) Cross-sectional versus longitudinal performance assessments in the management of diabetes. Medical Care, 42 (2 Suppl):II34-9.*



## Improving Patients' Communication with Doctors

This study reviewed 25 articles representing twenty intervention studies designed to increase patient participation during visits with their doctors. Most of the studies were done in outpatient or primary care



settings, about half were randomized controlled experimental designs, and half of the interventions were presented to patients in a written format.

The investigators found that over half of the interventions produced greater patient participation in the medical visit. The most significant changes were in more requests from patients for clarification, and more question-asking by patients. Of the ten written interventions, only two reported a significant increase in question-asking.

There were significant improvements in: perceptions of control over health, preferences for an active role in health care, recall of information, adherence to recommendations, attendance, and clinical outcomes, but few significant improvements in patient satisfaction.

The authors encourage further research examining the link between patient characteristics and intervention success in order to determine which interventions are most effective for particular groups of patients.

*Harrington J, Noble LM, Newman SP. (2004) Improving patients' communication with doctors: a systemic review of intervention studies. Patient Education and Counseling, 52(1):7-16.*

## Effects of a Tailored Follow-up Intervention

This study evaluated the effectiveness of follow-up tailored messages given to North Carolina participants in the WISEWOMAN (Well-Integrated Screening and Evaluation for Women Across the Nation) program at local health departments. Following a one-year behavior change program, 22 health departments in the state were randomly assigned to the follow-up intervention or the control condition. During the following year, intervention participants received six sets of computer-tailored health messages by mail, and two computer-tailored telephone counseling sessions. Data on the 511 low-income, midlife women were collected from 1999 to 2001 by telephone-administered surveys at pre- and post- follow-up intervention. Outcome measures included dietary and physical activity behaviors, beliefs, and attitudes.

The investigators found that intervention participants were significantly more likely to move forward into more advanced stages of physical activity, while control participants were significantly more likely to

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increase their level of dietary social support. Both groups maintained low levels of reported saturated fat and cholesterol intake. No changes in physical activity were found in either group.

The authors conclude that tailored follow-up messages, not requiring face-to-face contact with health care providers, helped participants maintain changes in eating habits and move forward in stages toward more physical activity, but did not affect other psychosocial or behavioral outcomes.

Jacobs AD, Ammerman AS, Ennett ST, et al. (2004) *Effects of a tailored follow-up intervention on health behaviors, beliefs, and attitudes. Journal of Women's Health, 13(5):557-68.*



## Performance Improvement Training

Every quarter, *Patient Education in Primary Care* will offer the opportunity to earn one hour of performance improvement training credit for a patient education topic of importance to primary care clinicians. To earn this credit, choose one of the following two options:

Read the entire July 2004 newsletter and provide brief answers to the questions below. Turn these in to your supervisor along with a copy of the newsletter

### OR

Organize a one-hour brown bag journal club or set aside time during a staff or team meeting to read the newsletter and discuss the questions below. Turn in a master list of participants along with a copy of the newsletter.

### Questions:

1. What strategies are currently used at your facility to address patient weight management and physical activity concerns? Is your facility considering implementation of the MOVE! program? What can you do to help?
2. Have you accessed the COLLAGE website within the past month? In what ways can you personally take advantage of COLLAGE tools and resources?
3. What strategies are used by clinicians at your facility to maintain follow-up contact with patients? What suggestions would you make to enhance these efforts?

## DO YOU HAVE ANY SUCCESSFUL PATIENT EDUCATION STRATEGIES THAT YOU WOULD LIKE TO SHARE WITH US?

Contact any of the following  
with your input:

**Barbara Hebert Snyder**  
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snyderbarbara@ameritech.net

**René Haas**  
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**Charlene Stokamer**  
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**Coming in  
OCTOBER:**

***Three  
VA patient  
education  
programs  
receive public  
health grants***

## PATIENT HEALTH EDUCATION IN PRIMARY CARE TASK FORCE:

**Dennis Cope, MD**  
Staff Physician  
Greater Los Angeles VA Health  
Care System  
Los Angeles, CA

**John Derderian, MBA, CHE**  
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**René Haas, RD, CDE**  
Patient Health Education Coordinator  
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**Linda Livingston, MSN, RN**  
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**Nancy McKinney, RN, CDE**  
Patient Educator  
Central Texas Veterans Health  
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**Barbara Hebert Snyder, MPH, CHES**  
President, Making Change  
Cleveland, OH

**Charlene Stokamer, RN, MPH, CHES**  
Patient Health Education Coordinator  
New York Harbor Health Care System  
New York, NY

**Jill Zahn, MLS**  
Patient Librarian  
VAMC Milwaukee, WI

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**Office of Primary and  
Ambulatory Care**

**TELL US ABOUT THE TOPICS YOU WOULD  
LIKE TO SEE COVERED IN FUTURE ISSUES**